

Crisis of Care on the Front Line of Health



Nola Lopez with Bryan Christie

**BASED ON
THE NOVEL**

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Does your doctor spend time talking to you? Do you see your doctor within 20 minutes of your appointment time? Are you getting the guidance you need to cope with a continuing health problem or multiple overlapping problems? Do you even have a personal physician who monitors your health and treats you promptly with skill and compassion?

A “no” answer to any of these questions — even to all of them — would not be surprising. Finding doctors who know their patients well and who deliver informed medical care with efficiency and empathy has become quite a challenge in America.

There is a crisis in medicine today, and it will not be fixed by any candidate’s proposal to provide [health insurance](#) for the 45 million Americans now without it. In fact, an increase in insured Americans could make it worse.

The crisis is a diminishing supply of primary care physicians, the doctors on the firing line — family physicians, internists, pediatricians, gerontologists and others — who practice the art and the science of medicine and who seek to put patients at least on a par with their pocketbooks.

According to a [study](#) published this month in The Journal of the American Medical Association, the number of medical students choosing to train in internal medicine is down, and young physicians are leaving the field. Other primary care specialties, including family medicine and gerontology, have also reported drops.

Primary care doctors spend far more time talking to patients and helping them avert health crises or cope with ailments that are chronic and incurable than they spend performing tests and procedures.

They are the doctors who ask pertinent questions, about health and also about life circumstances, and who listen carefully to how patients answer. They are the doctors who know their patients, and often the patients' families, and the circumstances and beliefs that can make health problems worse or impede effective treatment.

The problem is that in this era of managed care and reimbursements dictated by [Medicare](#) and other insurers, doctors don't get much compensation for talking to patients. They get paid primarily for procedures, from blood tests to surgery, and for the number of patients they see.

Most are burdened with paperwork and hours spent negotiating treatment options with insurers. And the payments they receive for services have not increased as the costs of running a modern medical practice have risen. To make ends meet and earn a reasonable income of, say, \$150,000 a year, many primary care doctors have to squeeze more and more patients into the workday.

"If you have only six to eight minutes per patient, which is the average under managed care, you're forced to concentrate on the acute problem and ignore all the rest," said Dr. Byron M. Thomashow, medical director of the Center for Chest Diseases at New York-Presbyterian Columbia Medical Center.

Yet, he said in an interview, in a study of more than 3,000 patients with [chronic obstructive pulmonary disease](#), 50 to 60 percent had one or more other illnesses, and 20 percent had more than 11 other problems that warranted medical attention.

“There just isn’t the time to address them all,” he said.

Dr. Alan J. Stein, an infectious disease specialist in private practice in Brooklyn who treats many patients with [H.I.V.](#), described his practice as “heavily cognitive.”

“I spend a lot of time talking to patients — listening to them, examining them, interpreting tests and figuring out what’s wrong,” he said in an interview. “I don’t do procedures in the office. Over the last 10 or 15 years, the income of procedure-based physicians like cardiologists has increased significantly, whereas for those in primary care it has remained the same.”

Dr. Michael Stewart, chairman of the department of otorhinolaryngology at New York-Presbyterian [Weill Cornell Medical Center](#), said in an interview that the challenge today was that “everything is going up except reimbursement. The tendency is to see more patients in a given amount of time, and so less time is spent with each patient.”

As a result, many who became doctors because they are genuinely interested in helping people get well and stay well or live a good life despite a continuing illness are increasingly disillusioned. Like Dr. Thomashow, a growing number of independent physicians are finding that the only way they can practice effectively is to not accept insurance and to ask patients to pay out of pocket.

Dr. Allen Bowling, a neurologist affiliated with the Rocky Mountain [Multiple Sclerosis](#) Center in Englewood, Colo., decided last year to convert his “busy, high overhead, insurance-based M.S. practice to one that has lower overhead, is moderately busy, and does not accept any private or government insurance.” He did that, he wrote in

Neurology Today in June, to give his patients “high-quality, personalized and moderately priced care with easy access to the neurologist.”

He is passionate about caring for multiple sclerosis patients, he said, but to continue practicing the kind of medicine they deserve, he had to change how he was reimbursed.

“Good doctors do drop out of managed care, and in the future I might have to drop out as well,” Dr. Stewart said. He acknowledged that specialists like him have an advantage.

“The amount of time I spend with patients is not such an issue,” he said. “But this is a big problem for primary care specialties where patients need a lot of time.”

Even some salaried academic physicians like Dr. Douglas A. Drossman, who runs a respected clinic where patients are treated regardless of ability to pay, often have to scramble for grants from foundations and industry to support their work with patients.

Dr. Drossman, co-director of the Center for Functional Gastrointestinal and Motility Disorders at the [University of North Carolina](#), said the salaries he and his colleagues receive do not cover the program’s costs. The program treats patients with life-disrupting chronic conditions like [irritable bowel syndrome](#), many of them referred by other diagnostic centers like the [Mayo Clinic](#).

“Many patients who come to us have been to countless doctors and told that there’s nothing organically wrong with them, it’s all in their heads and they just have to live with it,” Dr. Drossman said. “These patients wonder whether something has been missed. They’ve had all the tests. There’s no need to do more. But it takes time to help patients understand theirs is a real problem and to learn how to deal with it.”

Dr. Karen E. Hauer of the University of California, San Francisco, who directed the study of medical students, said in an interview that students were “turned off by the hassles in the practice environment — the paperwork, insurance issues, pace of work and expectations to get the work done quickly without having adequate time to spend with patients.”

This is a particular problem for doctors who treat the growing older population. Trends suggest there will not be nearly enough doctors for these patients, Dr. Hauer said.

Whatever the future of health care may hold for Americans, Dr. Thomashow said, “We need to go forward with something that keeps the humanity in medicine.”

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